MEDICAL HISTORY

PATIENT NAME		Birth Date			
Although dental personnel primarily tr have, or medication that you may be following questions.	-			•	• •
Have you ever been hospitalized or had Have you ever had a serious h	ead or neck injury? ○ Yes ○ ons, pills, or drugs? ○ Yes ○ nen-Fen or Redux? ○ Yes ○	NoIf yes, please explaNoIf yes, please explaNoIf yes, please explaNo	ain:		
Are you Do Do you use cont Women: Are you	u on a special diet? O Yes O you use tobacco? O Yes O rolled substances? O Yes O	No No			
Pregnant/Trying to get pregnant?		ntraceptives? () Yes ()	No Nursing?	○ Yes ○ No	
Aspirin Penicillin Other If yes, please explain:	Codeine 🗌 Local Ane	sthetics Ac	rylic 🗌 Metal	Latex	Sulfa drugs
Do you have, or have you had, any of AIDS/HIV Positive Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Anemia Yes No Angina Yes No Angina Yes No Anthritis/Gout Yes No Arthriticial Heart Valve Yes No Artificial Joint Yes No Asthma Yes No Blood Disease Yes No Bruise Easily Yes No Cancer Yes No Chemotherapy Yes No Congenital Heart Disorder Yes No Convulsions Yes No Have you ever had any serious illnes Comments:	Cortisone MedicineYesDiabetesYesDrug AddictionYesEasily WindedYesEmphysemaYesEpilepsy or SeizuresYesExcessive BleedingYesExcessive ThirstYesFainting Spells/DizzinessYesFrequent CoughYesFrequent DiarrheaYesFrequent HeadachesYesGlaucomaYesHay FeverYesHeart Attack/FailureYesHeart MurmurYesHeart PacemakerYesHeart Trouble/DiseaseYes	No Hepatitis A No Hepatitis B or C No Herpes No High Blood Press No High Blood Press No High Cholesterol No High Cholesterol No Hives or Rash No Hypoglycemia No Irregular Heartbe No Leukemia No Leukemia No Low Blood Press No Lung Disease No Mitral Valve Prola No Pain in Jaw Joint No Parathyroid Diseat No Psychiatric Care	 Yes Yes No 	Radiation Treatments Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Di Stroke Swelling of Limbs Thyroid Disease Tonsilitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice	Yes No Yes No
To the best of my knowledge, the que dangerous to my (or patient's) health					nation can be

_____ DATE _____